Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)

DO NOT DETACH TOP 2 FORMS - Reminder: ENCLOSE PA/DA with PA/DRF

MAIL TO
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL
PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH __/__/__

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (if different)

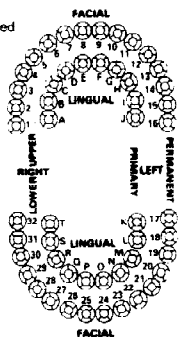
9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
  I II III IV V
- Cross out missing teeth
- Circle teeth to be extracted



Staple X-Ray Envelope Here

NUMBER OF X-RAYS _____

TYPE OF X-RAYS _____

An approved prior authorization does not guarantee payment. Prior authorized services: 1) are subject to the applicable terms of reimbursement issued by the Department; 2) must be provided consistent with a prior authorization, as approved or modified by the Department or its fiscal agent; and 3) are reimbursable only if and to the extent the provisions of s. HFS 107.02(3), Wis. Admin. Code, are met. Payment will not be made for services initiated prior to the approval or after the authorization expiration date. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, reimbursement will be allowed only if the service is not covered by the HMO and all other program requirements are met.

19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)
Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)
Date

MEDICAID CONSULTANT USE ONLY - DO NOT WRITE IN THIS SPACE

AUTHORIZATION: PROCEDURE(S) AUTHORIZED: QUANTITY AUTHORIZED:

☐ APPROVED GRANT DATE EXPIRATION DATE

☐ MODIFIED REASON _____

☐ DENIED REASON _____

☐ RETURN REASON _____

DATE MEDICAID CONSULTANT/ANALYST SIGNATURE

Appendix 20
SAMPLE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF)
(continued)

MAIL TO:
EDS
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PA/DRF
WISCONSIN MEDICAID DENTAL PRIOR AUTHORIZATION REQUEST FORM
(DO NOT WRITE IN THIS SPACE)
A.T. #
P.A. # 1271692

ICN #

1. PROCESSING TYPE (MARK ONE)
DENTAL - 124 ☐
ORTHO - 125 ☐

2. RECIPIENT'S MEDICAID ID NUMBER

3. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
(Write name exactly as it appears on the Medicaid ID card)

4. RECIPIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

5. DATE OF BIRTH ___/___/___

6. SEX M ☐ F ☐

7. BILLING PROVIDER NO.

8. PERFORMING PROVIDER NO. (If different)

9. BILLING PROVIDER NAME, ADDRESS, ZIP CODE
(If stamped, please stamp every copy)

10. PROVIDER TELEPHONE NO.

11. INDICATE IF THE SERVICE WILL BE PERFORMED IN:
- INPATIENT HOSPITAL (POS 1) ☐
- OUTPATIENT HOSPITAL (POS 2) ☐
- AMBULATORY SURG. CENTER (POS 8) ☐
- DENTAL OFFICE (POS 3) ☐

12. TOOTH #	13. PROCEDURE CODE	14. QUAN.	15. DESCRIPTION	16. FEE	
			18. TOTAL FEES		

17.
- Circle periodontal case type if applicable to the service requested
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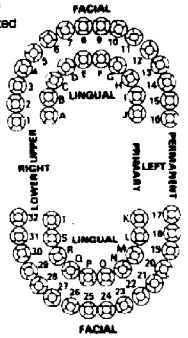

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TYPE OF X-RAYS _____

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19. RECIPIENT/GUARDIAN SIGNATURE (*Optional*)
Date

20. PERFORMING PROVIDER SIGNATURE
(If stamped, please stamp every copy)
Date

PROVIDER CHECKLIST
REQUESTS FOR PERIODONTICS, ENDODONTICS, AND SERVICES REQUIRING ENCLOSURES

HAVE YOU ENCLOSED?

X-rays for any of the following:
- Space maintainer ____
- Resin window SSC/resin crown ____
- Endodontics ____
- Partials and fixed prosthetics ____
- Surgical exposure of unerupted tooth ____
- Removal of foreign body ____

Periodontal charting required for any of the following procedures:
- Periodontal scaling and root planing ____
- Full mouth debridement ____
- Periodontal maintenance ____
- Partials *(for perio case types II, III, IV, and V only)* ____
- Fixed prosthodontics (abutment teeth) ____

HealthCheck referral for any of the following:
- Osteoplasty/Orthognathic surgery ____
- Surgical exposure of unerupted tooth ____
- Frenulectomy ____
- Orthodontics ____

Statement on speech impediment for:
- Palatal lift ____

TMJ surgery requirements - Enclose each of the following:
- Second surgical opinion ____
- Document non-surgical treatment ____
- Operative and post-operative plan of care ____
- X-ray report ____

When requesting upgraded crowns and upgraded partial dentures, the form "Provision of Upgraded Partial Denture and Crowns to Medicaid Recipients" in the Dental Provider Handbook (Part B) must be completed, signed, and attached to this form.

PROVIDER COPY - RETAIN FOR YOUR RECORDS
DISCARD UPON RECEIPT OF PROCESSED PRIOR AUTHORIZATION REQUEST